

FILED MAY 13 1955

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

13449

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

3823

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis,		c. CITY OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 5800 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) Adolph b. (Middle) c. (Last) Hilse.		4. DATE OF DEATH (Month) (Day) (Year) April 28, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH April 17, 1878
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant	9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME William Hilse		11b. MOTHER'S MAIDEN NAME Anna ?	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		12b. SOCIAL SECURITY NO. 495-26-6154	
13. NAME OF HUSBAND OR WIFE Catherine Tossik		14. INFORMANT'S SIGNATURE OR NAME Urvin Hilse	
15. ADDRESS 2640 Osage Ave.		16. CITIZEN OF WHAT COUNTRY? U S A	
17. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerosis Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>years</i> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Generalized Arteriosclerosis, Semiprobity</i> 18. DATE OF OPERATION 19. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	<i>4200</i>
22. I hereby certify that I attended the deceased from February 5, 1949 to April 28, 1955, that I last saw the deceased alive on April 28, 1955 and that death occurred at 9:10 A.M., from the causes and on the date stated above.			
23a. SIGNATURE <i>George M. Janaka, M.D.</i>		23b. ADDRESS 5800 Arsenal St.	
23c. DATE SIGNED April 28-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/30/55	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
DATE REC'D BY LOCAL REG. APR 29 1955	REGISTRAR'S SIGNATURE <i>Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home 1926 Allen Av	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Remond K. Lehman

Licensed Embalmer No. 339

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.